House Engrossed Senate Bill

~~insurance; fees; consent; limits~~
(now: insurance; fees; consent; medicare supplement)

State of Arizona
Senate
Fifty-fifth Legislature
Second Regular Session
2022

SENATE BILL 1118

AN ACT

AMENDING SECTIONS 20-167, 20-239, 20-381, 20-1133, 20-1379, 20-1382, 20-1583 AND 20-2310, ARIZONA REVISED STATUTES; RELATING TO INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-167, Arizona Revised Statutes, is amended to read:

20-167. Fees; definition

A. The director shall collect in advance the following fees, determined by the director, which are nonrefundable on payment:

	Not Less Than:	Not More Than:
1. For filing charter documents:		
(a) Original charter documents, articles of incorporation, bylaws, or record of organization of insurers, or certified copies thereof, required to be filed with the director and not also subject to filing in the office of the corporation commission	$ 40.00	$ 115.00
(b) Amended charter documents	15.00	45.00
(c) No charge or fee shall be required for filing with the director any of such documents also required by law to be filed in the office of the corporation commission		
2. Certificate of authority:		
(a) Issuance:		
Fraternal benefit societies	$ 15.00	$ 45.00
Medical or hospital service corporations, health care services organizations or prepaid dental plan organizations	40.00	115.00
Mechanical reimbursement reinsurers	150.00	450.00
All other insurers	100.00	295.00
(b) Renewal:		
Fraternal benefit societies	15.00	45.00
Medical or hospital service corporations, health care services organizations or prepaid dental plan organizations	40.00	115.00

Domestic stock life insurers, domestic stock disability insurers or domestic stock life and disability insurers	750.00	2,250.00
Domestic life reinsurers, domestic disability reinsurers or domestic life and disability reinsurers	2,250.00	5,500.00
Mechanical reimbursement reinsurers	2,250.00	5,500.00
All other insurers	70.00	205.00
3. Certificate of registration as an administrator or application for renewal under section 20-485.12	$ 100.00	$ 295.00
4. Authority to solicit applications for and issue policies by means of mechanical vending machines	$ 30.00	$ 90.00
5. Service company permit	$ 150.00	$ 450.00
6. Application for motor vehicle service contract program approval	$ 150.00	$ 450.00
7. Life care contract application or annual report	$ 225.00	$ 675.00
8. Filing annual statement	$ 150.00	$ 450.00
9. Annual statement filing for exempt insurer transacting life insurance, disability insurance or annuity business pursuant to section 20-401.05	$ 65.00	$ 100.00
10. Licenses and examinations:		
(a) Licenses:		
Surplus lines broker's license, quadrennially	$ 600.00	$1,000.00
All other licenses, quadrennially	60.00	180.00
(b) Examinations for license:		
Examination on laws and one kind of insurance	8.00	25.00
Examination on laws and two or more kinds of insurance	15.00	45.00
11. Miscellaneous:		
Fee accompanying service of process on director	$ 8.00	$ 25.00

Certificate of director, under seal	~~1.50~~ 0.00	5.00
Copy of document filed in director's office, per page	0.50	0.75

B. Except as provided in section 20-1098.18, the director shall deposit, pursuant to sections 35-146 and 35-147, all fees collected pursuant to this section in the state general fund. A refund is not allowed for any unused portion of a fee, and the director shall not prorate fees.

C. The license fees prescribed by this section shall be payment in full of all demands for all state, county, district and municipal license fees, license taxes, business privilege taxes and business privilege fees and charges of every kind.

D. The director may contract for the examination for licensing adjusters, insurance producers, bail bond agents, risk management consultants and surplus lines brokers. If the director does so, the fee for examinations for licenses pursuant to this section is payable directly to the contractor by the applicant for examination. The director may agree to a reasonable examination fee to be charged by the contractor. The fee may exceed the amounts prescribed in this section.

E. The director may contract with a voluntary domestic organization of surplus lines brokers to perform any transaction prescribed in chapter 2, article 5 of this title, including the acceptance or maintenance of the reports required by section 20-408. The director may allow the contractor to charge a stamping fee. The surplus lines broker shall pay the stamping fee established pursuant to this section directly to the contractor.

F. Captive insurers shall pay certificate of authority issuance and renewal fees as prescribed by the director.

G. For the purposes of this section, "stamping fee" means a reasonable filing fee charged by a contractor for any transaction prescribed in chapter 2, article 5 of this title, including the acceptance or maintenance of the reports required by section 20-408.

Sec. 2. Section 20-239, Arizona Revised Statutes, is amended to read:

20-239. Electronic communications and records; applicability; definitions

A. Any notice to a party or any other document that is required under this title in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored and presented by electronic means if it meets the requirements of title 44, chapter 26, article 1. If an insurer uploads a document or notice to a portal or secure website, the insurer shall send a separate notice to the party that specifies that the document or notice has been uploaded and that includes a description of the document or notice that has been uploaded.

B. An insurer may deliver a notice or document by electronic means to a party pursuant to this section if the party electronically consents to that method of electronic delivery and has not withdrawn consent. A named insured that effectuates insurance transactions by electronic means shall be deemed to have consented to receive notices and documents by electronic means in accordance with this section unless the named insured opts out of electronic delivery and elects delivery by hard copy.

C. EITHER an oral communication WITH A CONTEMPORANEOUS WRITTEN RECORD MADE OF THE COMMUNICATION or ~~a~~ AN ARCHIVED recording of an oral communication SUBJECT TO THE INSURER'S WRITTEN RECORD RETENTION POLICY ~~does not~~ SHALL qualify as consent for the purposes of this section. THE ORAL CONSENT PRESCRIBED IN THIS SUBSECTION APPLIES ONLY TO AN AGREEMENT TO THE USE OF ELECTRONIC COMMUNICATION WITH THE INSURER AND IS NOT AN AGREEMENT BY THE INSURED TO ANY SPECIFIC INSURANCE POLICY OR COVERAGE OR ANY OTHER INSURANCE MATTER.

D. Notwithstanding subsection A of this section, an insurer sending a notice pursuant to section 20-1632, subsection A, for a period of five years after the date of the notice, shall maintain in its files verification that the notice was sent by electronic means with a United States postal service electronic postmark or another email delivery service that provides electronic postmarks substantially similar to a United States postal service electronic postmark. The verification must contain sufficient information from which the department may determine that the notice was properly sent.

E. An insurer providing notice to an insured pursuant to section 20-1632 by electronic means shall also send that notice to the named insured by United States postal service certified mail, certificate of mailing or first class mail using intelligent mail barcode or another similar tracking method used or approved by the United States postal service pursuant to section 20-1632 if either of the following applies:

1. The notice being electronically delivered is rejected for delivery or returned to the insurer.

2. The insurer becomes aware that the email address provided by the party is no longer valid.

F. Delivery of a notice or document pursuant to this section is equivalent to any delivery method required or allowed under this title, including delivery by the United States postal service by first class mail, postage prepaid, certified mail, certificate of mailing or first class mail using intelligent mail barcode or another similar tracking method used or approved by the United States postal service.

G. After the party elects to receive notices and documents by electronic means, if a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or

retain a subsequent notice or document to which the consent applies, the insurer must inform the party of:

1. The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

2. The party's right to withdraw consent without the imposition of any fee, condition or consequence.

H. This section does not affect the requirements related to content or timing of any notice or document required under this title.

I. If a provision of this title expressly requires verification or acknowledgment of receipt of a notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

J. The legal effectiveness, validity or enforceability of any insurance contract or policy executed by a party may not be denied solely because the insurer failed to obtain electronic consent or confirmation of consent.

K. A party's withdrawal of consent:

1. Does not affect the legal effectiveness, validity or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

2. Is effective within seven days after the insurer receives the withdrawal.

L. If an insurer fails to comply with subsection G of this section, the party may treat that failure as a withdrawal of consent for the purposes of this section.

M. This section does not apply to a notice or document delivered by an insurer in an electronic format before July 24, 2014 to a party who, before that date, has consented to receive a notice or document in an electronic format as otherwise provided by law.

N. If a party's consent to receive certain notices or documents in an electronic format is on file with an insurer before July 24, 2014 and the insurer intends to deliver additional notices or documents to that party in an electronic format pursuant to this section, before delivering the additional notices or documents electronically the insurer must notify the party of both of the following:

1. The notices or documents that may be delivered by electronic means under this section that were not previously delivered electronically.

2. The party's right to withdraw consent to have notices or documents delivered by electronic means.

O. An insurer may not charge a fee to a party who does not consent to receive notices or documents by electronic means and who chooses to receive the notices or documents in hard copy.

P. This section applies only to property, casualty, disability, marine and transportation, surety, prepaid legal, prepaid dental, title, identity theft, workers' compensation and life insurance policies and annuities that are subject to this title, including policies and contracts issued by health care services organizations and hospital, medical, dental and optometric service corporations.

Q. This section does not modify, limit or supersede the electronic signatures in global and national commerce act (P.L. 106-229; 15 United States Code sections 7001 through 7031).

R. For the purposes of this section:

1. "Delivered by electronic means" includes either:

(a) The delivery to an email address at which a party has consented to receive notices or documents.

(b) The posting on an electronic network or site accessible via the internet or a mobile application, computer, mobile device, tablet or other electronic device, together with a separate notice of the posting that includes a description of the document or notice that has been posted and that is provided by email to the email address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party.

2. "Party" means a recipient of any notice or document as part of an insurance transaction, including an applicant, an insured or a policyholder.

Sec. 3. Section 20-381, Arizona Revised Statutes, is amended to read:

20-381. Definitions

In this article, unless the context otherwise requires:

1. "Advisory organization":

(a) Means any person other than a single insurer who assists TWO OR MORE insurers or rate service organizations in the making of rates by compiling and furnishing loss or expense statistics or other statistical information and data, or by the submission of recommendations as to rates, forms or supplementary rate information. ~~Advisory organization~~

(b) Does not include a joint underwriting association, any actuarial or legal consultant, any employee of an insurer or insurers under common control or management or their employees or manager.

2. "Loss cost adjustment":

(a) Means that portion of a rate filed by an insurer with the director that includes the insurer's general expenses, total product expenses, taxes, licenses and fee expenses and underwriting profit and contingencies. ~~Loss cost adjustment~~

(b) Does not include loss adjustment expenses or prospective loss costs.

3. "Loss cost modification factor" means that rating factor filed by an insurer with the director for the purpose of modifying the rate service organization's prospective loss cost filing.

4. "Prospective loss costs" means the historical aggregate losses and loss adjustment expenses filed by a rate service organization with the director on which a portion of a rate is based, adjusted through actuarial trending to a future point in time and developed to their ultimate values.

5. "Rate":

(a) Means that cost of insurance per exposure unit whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit and individual insurer variation in loss experience before any application of individual risk variations based on loss or expense considerations. ~~Rate~~

(b) Does not include the minimum premium.

6. "Rate service organization":

(a) Means any person other than a single insurer who assists insurers by compiling and furnishing loss or expense statistics and recommending, making or filing rates, forms or supplementary rate information. ~~Rate service organization~~

(b) Does not include a joint underwriting association, any actuarial or legal consultant, any employee of an insurer or insurers under common control or management, or their employees or manager.

7. "Supplementary rate information":

(a) Means any manual or plan of rates, statistical plan, classification, rating schedule, minimum premium, schedule of fees, including membership fees charged by a reciprocal or mutual insurer, rating rule, rate related underwriting rule and ~~any~~ other information used by an insurer in making rates. ~~Supplementary rate information~~

(b) Does not include the final rate pages that combine the prospective loss costs with the loss cost adjustments.

Sec. 4. Section 20-1133, Arizona Revised Statutes, is amended to read:

20-1133. Medicare supplement insurance; early enrollment discounts; applicability

A. The director shall adopt ~~those~~ rules ~~as are~~ necessary to comply with the requirements of the social security disability amendments of 1980 (P.L. 96-265; 42 United States Code section 1395ss) and any federal laws or regulations pertaining to that section, so that this state may retain its full authority to regulate minimum standards for medicare supplement insurance.

B. FOR THE PURPOSES OF THIS SECTION, AN INSURER MAY FILE FOR MEDICARE SUPPLEMENT RATES THAT INCLUDE AN EARLY ENROLLMENT DISCOUNT THAT WILL NOT BE CONSIDERED AN ATTAINED AGE RATING STRUCTURE. AN EARLY ENROLLMENT DISCOUNT SHALL DIMINISH OVER A PERIOD OF TIME AND IS ONLY

AVAILABLE TO ENROLLEES WHO PURCHASE THE PLAN WITHIN THE EARLY ENROLLMENT PERIOD DESIGNATED BY THE INSURER. INSURERS SHALL DISCLOSE TO ALL APPLICANTS HOW THE EARLY ENROLLMENT DISCOUNT WILL DIMINISH OVER TIME.

~~B.~~ C. Subject to the other limitations provided in this subsection, ~~no~~ A benefit mandated in this title for health insurance policies ~~shall~~ DOES NOT apply to medicare supplement insurance policies unless ~~such~~ THE mandated policy ~~benefits are~~ BENEFIT IS set forth in rules adopted pursuant to this section or unless the statute mandating THE policy ~~benefits~~ BENEFIT expressly states that it is made specifically applicable to medicare supplement insurance policies. ~~No~~ A medicare supplement insurance policy ~~shall~~ MAY NOT contain any exclusion for services provided by any type of properly licensed health care provider if the provider's services are eligible for medicare reimbursement and if the specific services in question would be covered by medicare. ~~In no event shall~~ The scope of benefits of a medicare supplement policy MAY NOT be less than the minimum level of benefits established by federal law.

~~C.~~ D. Notwithstanding any other provision of this title, rules adopted pursuant to this section apply to insurance ~~furnished~~ PROVIDED under disability insurance policies, under subscription contracts of hospital, medical, dental or optometric service corporations, under certificates of fraternal benefit societies, under evidences of coverage of health care services organizations and under coverages issued by any other insurer, which policies, contracts, certificates, membership coverages, evidences of coverage and coverages are delivered or issued for delivery in this state on or after the effective date of rules adopted pursuant to subsection A OF THIS SECTION. In adopting the rules required by subsection A OF THIS SECTION, the director shall prescribe an effective date of the rules that will allow insurers sufficient time to bring their forms and practices into compliance with the requirements of the rule.

Sec. 5. Section 20-1379, Arizona Revised Statutes, is amended to read:

20-1379. Guaranteed availability of individual health insurance coverage; prior group coverage; definitions

A. Every health care insurer that offers individual health insurance coverage in the individual market in this state shall provide guaranteed availability of coverage to an eligible individual who desires to enroll in individual health insurance coverage and shall not:

1. Decline to offer that coverage to, or deny enrollment of, that individual.

2. Impose any preexisting condition exclusion for that coverage.

B. Every health care insurer that offers individual health insurance coverage in the individual market in this state shall offer all policy forms of health insurance coverage that are designed for, that are

made generally available and actively marketed to and that enroll both eligible or other individuals. A health care insurer that offers only one policy form in the individual market complies with this section by offering that form to eligible individuals. A health care insurer also may comply with the requirements of this section by electing to offer at least two different policy forms to eligible individuals as provided by subsection C of this section.

C. A health care insurer shall meet the requirements prescribed in subsection B of this section if:

1. The health care insurer offers at least two different policy forms, both of which are designed for, are made generally available and actively marketed to and enroll both eligible and other individuals.

2. The offer includes at least either:

(a) The policy forms with the largest and next to the largest earned premium volume of all policy forms offered by the health care insurer in this state in the individual market during a period not to exceed the preceding two calendar years.

(b) A choice of two policy forms with representative coverage, consisting of a lower level of coverage policy form and a higher level of coverage policy form, each of which includes benefits that are substantially similar to other individual health insurance coverage offered by the health care insurer in this state and each of which is covered by a method that provides for risk adjustment, risk spreading or a risk spreading mechanism among the health care insurer's policies.

D. The health care insurer's election pursuant to subsection C of this section is effective for policies offered during a period of at least two years.

E. If a health care insurer offers individual health insurance coverage in the individual market through a network plan, the health care insurer may do both of the following:

1. Limit the individuals who may be enrolled under health insurance coverage to those who live, reside or work within the service area for a network plan.

2. Within the service area of a network plan, deny health insurance coverage to individuals if the health care insurer has demonstrated, if required, to the director that both:

(a) The health care insurer will not have the capacity to deliver services adequately to additional individual enrollees because of the health care insurer's obligations to existing group contract holders and enrollees and individual enrollees.

(b) The health care insurer is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

F. A health care insurer may deny individual health insurance coverage in the individual market to an eligible individual if the health care insurer demonstrates to the director that the health care insurer:

1. Does not have the financial reserves necessary to underwrite additional coverage.

2. Is denying coverage uniformly to all individuals in the individual market in this state pursuant to state law and without regard to any health status-related factor of the individuals and without regard to whether the individuals are eligible individuals.

G. If a health care insurer denies health insurance coverage in this state pursuant to subsection F of this section, the health care insurer shall not offer that coverage in the individual market in this state for one hundred eighty days after the date the coverage is denied or until the health care insurer demonstrates to the director that the health care insurer has sufficient financial reserves to underwrite additional coverage, whichever is later.

H. An accountable health plan as defined in section 20-2301 that offers conversion policies on an individual or group basis in connection with a health benefits plan pursuant to this title is not a health care insurer that offers individual health insurance coverage solely because of the offer of a conversion policy.

I. ~~Nothing in~~ This section DOES NOT:

1. ~~Creates~~ CREATE additional restrictions on the amount of the premium rates that a health care insurer may charge an individual for health insurance coverage provided in the individual market.

2. ~~Prevents~~ PREVENT a health care insurer that offers health insurance coverage in the individual market from establishing premium rates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

3. ~~Requires~~ REQUIRE a health care insurer that offers only short-term limited duration insurance or limited benefit coverage to individuals and no other coverage to individuals in the individual market to offer individual health insurance coverage in the individual market.

4. ~~Requires~~ REQUIRE a health care insurer offering health care coverage only on a group basis or through one or more bona fide associations, or both, to offer health insurance coverage in the individual market.

J. A health care insurer shall provide, without charge, a written certificate of creditable coverage as described in this section for creditable coverage occurring after June 30, 1996 if the individual:

1. Ceases to be covered under a policy offered by a health care insurer. An individual who is covered by a policy that is issued on a group basis by a health care insurer, that is terminated or not renewed at

the choice of the sponsor of the group and where the replacement of the coverage is without a break in coverage is not entitled to receive the certification prescribed in this paragraph but is instead entitled to receive the certification prescribed in paragraph 2 of this subsection.

2. Requests certification from the health care insurer within twenty-four months after the coverage under a health insurance coverage policy offered by a health care insurer ceases.

K. The certificate of creditable coverage provided by a health care insurer is a written certification of the period of creditable coverage of the individual under the health insurance coverage offered by the health care insurer. The department may enforce and monitor the issuance and delivery of the notices and certificates by health care insurers as required by this section, section 20-1380, the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations adopted to implement the health insurance portability and accountability act of 1996. NOTWITHSTANDING ANY OTHER LAW, AN INSURER IS NOT REQUIRED TO PROVIDE A CERTIFICATE OF CREDITABLE COVERAGE IF THE FEDERAL LAWS THAT REQUIRE PROVIDING A CERTIFICATE OF CREDITABLE COVERAGE ARE SUPERSEDED BY THE PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS.

L. Any health care insurer, accountable health plan or other entity that issues health care coverage in this state, as applicable, shall issue and accept a certificate of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.

2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.

3. The name, address and telephone number of the issuer providing the certificate.

4. The telephone number to call for further information regarding the certificate.

5. One of the following:

(a) A statement that the individual has at least eighteen months of creditable coverage. For the purposes of this subdivision, "eighteen months" means five hundred forty-six days.

(b) Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.

6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.

7. The consumer assistance telephone number for the department.

8. The following statement in at least fourteen-point type:

Important Notice!

Keep this certificate with your important personal records to protect your rights under the health insurance portability and accountability act of 1996 ("HIPAA"). This certificate is proof of your prior health insurance coverage. You may need to show this certificate to have a guaranteed right to buy new health insurance ("Guaranteed issue"). This certificate may also help you avoid waiting periods or exclusions for preexisting conditions. Under HIPAA, these rights are guaranteed only for a very short time period. After your group coverage ends, you must apply for new coverage within 63 days to be protected by HIPAA. If you have questions, call the Arizona department of insurance and financial institutions.

M. A health care insurer has satisfied the certification requirement under this section if the insurer offering the health benefits plan provides the certificate of creditable coverage in accordance with this section within thirty days after the event that triggered the issuance of the certificate.

N. Periods of creditable coverage for an individual are established by the presentation of the certificate described in this section and section 20-2310. In addition to the written certificate of creditable coverage as described in this section, individuals may establish creditable coverage through the presentation of documents or other means. In order to make a determination that is based on the relevant facts and circumstances of the amount of creditable coverage that an individual has, a health care insurer shall take into account all information that the insurer obtains or that is presented to the insurer on behalf of the individual.

O. A health care insurer shall calculate creditable coverage according to the following rules:

1. The health care insurer shall allow an individual credit for each day the individual was covered by creditable coverage.

2. The health care insurer shall not count a period of creditable coverage for an individual enrolled under any form of health insurance coverage if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered by any creditable coverage.

3. The health care insurer shall not include any period that an individual is in a waiting period or an affiliation period for any health coverage or is awaiting action by a health care insurer on an application for the issuance of health insurance coverage when the health care insurer determines the continuous period pursuant to paragraph 1 of this subsection.

4. The health care insurer shall not include any period that an individual is waiting for approval of an application for health care coverage, provided the individual submitted an application to the health care insurer for health care coverage within sixty-three consecutive days after the individual's most recent creditable coverage.

5. The health care insurer shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The health care insurer shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer, is in a waiting period for benefits under a health benefits plan offered by an accountable health plan or is in an affiliation period.

6. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period the health care insurer shall count a period of creditable coverage without regard to the specific benefits covered during that period.

P. An individual is an eligible individual if, on the date the individual seeks coverage pursuant to this section, the individual has an aggregate period of creditable coverage as defined and calculated pursuant to this section of at least eighteen months and all of the following apply:

1. The most recent creditable coverage for the individual was under a plan offered by:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code sections 1001 through 1461).

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A governmental plan as defined in the employee retirement income security act of 1974, including a plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the United States.

(d) An accountable health plan as defined in section 20-2301.

2. The individual is not eligible for coverage under:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A health benefits plan issued by an accountable health plan as defined in section 20-2301.

(c) Part A or part B of title XVIII of the social security act.

(d) Title 36, chapter 29 or any other plan established under title XIX of the social security act, and the individual does not have other health insurance coverage.

3. The most recent coverage within the coverage period was not terminated based on any factor described in section 20-2309, subsection B, paragraph 1 or 2 relating to nonpayment of premiums or fraud.

4. The individual was offered and elected the option of continuation coverage under a COBRA continuation provision pursuant to the consolidated omnibus budget reconciliation act of 1985 (P.L. 99-272; 100 Stat. 82) or a similar state program.

5. The individual exhausted the continuation coverage pursuant to the consolidated omnibus budget reconciliation act of 1985.

Q. Notwithstanding subsection P of this section, an individual is an eligible individual if:

1. The individual is an individual enrollee in a health care services organization that is domiciled in this state on the date that the health care services organization is declared insolvent, including any health care services organization that is not an accountable health plan as defined in section 20-2301.

2. The individual's coverage terminates during the delinquency proceeding, after the health care services organization is declared insolvent.

3. The individual satisfies the requirements of an eligible individual as prescribed in this section other than the required period of creditable coverage.

R. Notwithstanding subsection P of this section, a newborn child, adopted child or child placed for adoption is an eligible individual if the child was timely enrolled and otherwise would have met the definition of an eligible individual as prescribed in this section other than the required period of creditable coverage and the child is not subject to any preexisting condition exclusion or limitation if the child has been continuously covered under health insurance coverage or a health benefits plan offered by an accountable health plan since birth, adoption or placement for adoption.

S. If a health care insurer imposes a waiting period for coverage of preexisting conditions, within a reasonable period of time after

receiving an individual's proof of creditable coverage and not later than the date by which the individual must select an insurance plan, the health care insurer shall give the individual written disclosure of the insurer's determination regarding any preexisting condition exclusion period that applies to that individual. The disclosure shall include all of the following information:

1. The period of creditable coverage allowed toward the waiting period for coverage of preexisting conditions.

2. The basis for the insurer's determination and the source and substance of any information on which the insurer has relied.

3. A statement of any right the individual may have to present additional evidence of creditable coverage and to appeal the insurer's determination, including an explanation of any procedures for submission and appeal.

T. This section and section 20-1380 apply to all health insurance coverage that is offered, sold, issued, renewed, in effect or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

U. For the purposes of this section and section 20-1380 as applicable:

1. "Affiliation period" has the same meaning prescribed in section 20-2301.

2. "Bona fide association" means, for health care coverage issued by a health care insurer, an association that meets the requirements of section 20-2324.

3. "Creditable coverage" means coverage solely for an individual, other than limited benefits coverage, under any of the following:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A health benefits plan issued by an accountable health plan as defined in section 20-2301.

(d) Part A or part B of title XVIII of the social security act.

(e) Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.

(f) Title 10, chapter 55 of the United States Code.

(g) A medical care program of the Indian health service or of a tribal organization.

(h) A health benefits risk pool operated by any state of the United States.

(i) A health plan offered pursuant to title 5, chapter 89 of the United States Code.

(j) A public health plan as defined by federal law.

(k) A health benefit plan pursuant to section 5(e) of the peace corps act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through 2523).

(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation.

(m) A policy or contract issued by a health care insurer or an accountable health plan to a member of a bona fide association.

4. "Delinquency proceeding" has the same meaning prescribed in section 20-611.

5. "Different policy forms" means variations between policy forms offered by a health care insurer, including policy forms that have different cost sharing arrangements or different riders.

6. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analyses of genes or chromosomes.

7. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation.

8. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health care services organization including:

(a) Health status.

(b) Medical condition, including physical and mental illness.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.

(h) The existence of a physical or mental disability.

9. "Higher level of coverage" means a policy form for which the actuarial value of the benefits under the health insurance coverage offered by a health care insurer is at least fifteen percent more than the actuarial value of the health insurance coverage offered by the health

care insurer as a lower level of coverage in this state but not more than one hundred twenty percent of a policy form weighted average.

10. "Individual health insurance coverage" means health insurance coverage offered by a health care insurer to individuals in the individual market but does not include limited benefit coverage or short-term limited duration insurance. A health care insurer that offers limited benefit coverage or short-term limited duration insurance to individuals and no other coverage to individuals in the individual market is not a health care insurer that offers health insurance coverage in the individual market.

11. "Limited benefit coverage" has the same meaning prescribed in section 20-1137.

12. "Lower level of coverage" means a policy form offered by a health care insurer for which the actuarial value of the benefits under the health insurance coverage is at least eighty-five percent but not more than one hundred percent of the policy form weighted average.

13. "Network plan" means a health care plan provided by a health care insurer under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of providers either under contract with a health care insurer licensed pursuant to chapter 4, article 3 of this title or under contract with a health care insurer in accordance with the determination made by the director pursuant to section 20-1053 regarding the geographic or service area in which a health care insurer may operate.

14. "Policy form weighted average" means the average actuarial value of the benefits provided by a health care insurer that issues health coverage in this state that is provided by either the health care insurer or, if the data are available, by all health care insurers that issue health coverage in this state in the individual health coverage market during the previous calendar year, except coverage pursuant to this section, weighted by the enrollment for all coverage forms.

15. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under the health insurance policy or other contract that provides health coverage benefits. A genetic condition is not a preexisting condition in the absence of a diagnosis of the condition related to the genetic information and shall not result in a preexisting condition limitation or preexisting condition exclusion.

16. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health insurance policy or other contract that provides health coverage benefits.

17. "Short-term limited duration insurance" has the same meaning prescribed in section 20-1384 and is not intended or marketed as health insurance coverage subject to guaranteed issuance or guaranteed renewal provisions of the laws of this state but is creditable coverage within the meaning of this section and section 20-2301.

Sec. 6. Section 20-1382, Arizona Revised Statutes, is amended to read:

20-1382. Health care insurers; reporting requirements

A. On or before March 1 of each year, each health care insurer shall submit to the director a written report that contains the following information:

1. The number of eligible individuals covered by policies that were written by that health care insurer in the individual market during the previous calendar year.

2. The number of individuals covered by policies that were issued other than to eligible individuals during the previous calendar year.

3. The earned premium for each category of individual policy for the previous calendar year.

4. The total number of eligible individuals covered by policies that were issued by the health care insurer as of the end of the previous calendar year.

B. Each health care insurer shall submit the following information to the department, if applicable, to demonstrate compliance with sections 20-1379, 20-1380 and 20-1381:

1. The health care insurer's name and address.

2. The identification, form number and summary of all products that the health care insurer offers in the individual market.

3. If the health care insurer elects the option prescribed in section 20-1379, subsection C, paragraph 2, subdivision (a) the data on premium volumes of all policy forms that the health care insurer offers in the individual market and the number of individuals who are covered under each form during the preceding calendar year.

4. If the health care insurer elects the option prescribed in section 20-1379, subsection C, paragraph 2, subdivision (b) the data, assumptions and methods used to calculate the actuarial values of the two representative policy forms.

5. An explanation of how the health care insurer is complying with sections 20-1379, 20-1380 and 20-1381.

6. A list of all products, including all marketing material, that the health care insurer is making or will make available to eligible individuals and an explanation of how the health care insurer will inform individuals of these policy forms.

7. A description of the risk spreading and financial subsidization mechanism.

C. The health care insurer shall submit the information described in subsection B of this section to the department by March 1 of each year.

D. If all or part of the information required by subsection B, paragraph 5, 6 or 7 of this section has not changed since the health care insurer's last previous submission, instead of refiling the information the health care insurer may indicate the information that has not changed.

E. NOTWITHSTANDING ANY OTHER LAW, AN INSURER IS NOT REQUIRED TO COMPLY WITH THE REPORTING REQUIREMENTS OF THIS SECTION IF THE FEDERAL LAWS THAT REQUIRE PROVIDING A CERTIFICATE OF CREDITABLE COVERAGE ARE SUPERSEDED BY THE PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS.

Sec. 7. Section 20-1583, Arizona Revised Statutes, is amended to read:

20-1583. Title insurance agencies; use of corporate names

~~A. An agent for a title insurer shall not adopt a corporate or business name containing the words "title insurance", "title guaranty" or "title guarantee" or other words indicating that the agent is in the business of title insurance, unless those words are followed by the words "agent" or "agency". In any stationery, sign, advertising, brochure, literature or similar writing issued or used by the agent, the words "agent" or "agency" shall be in the same size and type as the words preceding them. This section does not apply to a title insurer acting as agent for another title insurer.~~

~~B.~~ A title insurer may authorize the use of its corporate name or a portion of the name to a title insurance agency ~~if the name of the title insurance agency complies with subsection A~~.

~~C. For purposes of this section only, a title insurer is not responsible for a violation of this section by an agent for the title insurer and is not liable for a civil penalty that is imposed on a title insurance agent.~~

Sec. 8. Section 20-2310, Arizona Revised Statutes, is amended to read:

20-2310. Discrimination prohibited; preexisting conditions; wellness programs

A. Except as provided in subsection B of this section, a health benefits plan may not deny, limit or condition the coverage or benefits based on a person's health status-related factors or a lack of evidence of insurability.

B. A health benefits plan shall not exclude coverage for preexisting conditions, except that:

1. A health benefits plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise

covered from the time of their birth or to persons who satisfy the portability requirements under section 20-2308.

2. The accountable health plan shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.

C. A health benefits plan shall not include an affiliation period in a policy unless the affiliation period satisfies the requirements prescribed in 45 Code of Federal Regulations section 146.119(b).

D. On request of a health benefits plan, a person who provides coverage during a period of continuous coverage with respect to a covered individual shall promptly disclose the coverage provided to the covered individual, the period of the coverage and the benefits provided under the coverage.

E. The accountable health plan shall calculate creditable coverage according to the following rules:

1. The accountable health plan shall give an individual credit for each day the individual was covered by creditable coverage.

2. The accountable health plan shall not count a period of creditable coverage for an individual enrolled in a health benefits plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.

3. The accountable health plan shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period or an affiliation period for any health coverage.

4. The accountable health plan shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The accountable health plan shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer, is in a waiting period for benefits under a health benefits plan offered by an accountable health plan or is in an affiliation period.

5. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period the accountable health plan shall count a period of creditable coverage without regard to the specific benefits covered during that period.

6. An accountable health plan shall not impose any preexisting condition exclusion in the case of an individual who is covered under creditable coverage thirty-one days after the individual's date of birth.

7. An accountable health plan shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.

F. An accountable health plan shall provide the certificate of creditable coverage described in subsection G of this section without charge for creditable coverage occurring after June 30, 1996 if the individual:

1. Ceases to be covered under a health benefits plan offered by an accountable health plan or otherwise becomes covered under a COBRA continuation provision. An individual who is covered by a health benefits plan that is offered by an accountable health plan, that is terminated or not renewed at the choice of the employer and where the replacement of the health benefits plan is without a break in coverage is not entitled to receive the certification prescribed in this paragraph but is instead entitled to receive the certifications prescribed in paragraphs 2 and 3 of this subsection.

2. Who was covered under a COBRA continuation provision ceases to be covered under the COBRA continuation provision.

3. Requests certification from the accountable health plan within twenty-four months after the coverage under a health benefits plan offered by an accountable health plan ceases.

G. The certificate of creditable coverage provided by an accountable health plan is a written certification of:

1. The period of creditable coverage of the individual under the accountable health plan and any applicable coverage under a COBRA continuation provision.

2. Any applicable waiting period or affiliation period imposed on an individual for any coverage under the accountable health plan.

H. Any accountable health plan that issues health benefits plans in this state, as applicable, shall issue and accept a written certificate of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.

2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.

3. The name, address and telephone number of the issuer providing the certificate.

4. The telephone number to call for further information regarding the certificate.

5. One of the following:

(a) A statement that the individual has at least eighteen months of creditable coverage. For the purposes of this subdivision, "eighteen months" means five hundred forty-six days.

(b) Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.

6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.

7. The consumer assistance telephone number for the department.

8. The following statement in at least fourteen-point type:

Important notice!

Keep this certificate with your important personal records to protect your rights under the health insurance portability and accountability act of 1996 ("HIPAA"). This certificate is proof of your prior health insurance coverage. You may need to show this certificate to have a guaranteed right to buy new health insurance ("Guaranteed issue"). This certificate may also help you avoid waiting periods or exclusions for preexisting conditions. Under HIPAA, these rights are guaranteed only for a very short time period. After your group coverage ends, you must apply for new coverage within 63 days to be protected by HIPAA. If you have questions, call the Arizona department of insurance and financial institutions.

I. An accountable health plan may provide any certification pursuant to subsection F, paragraph 1 of this section at the same time the accountable health plan sends the notice required by the applicable COBRA continuation provision.

J. An accountable health plan has satisfied the certification requirement under this section if the accountable health plan offering the health benefits plan provides the prescribed certificate in accordance with this section within thirty days after the event that triggered the issuance of the certification.

K. If an accountable health plan imposes a waiting period for coverage of preexisting conditions, within a reasonable period of time after receiving an individual's proof of creditable coverage and not later than the date by which the individual must select an insurance plan, the accountable health plan shall give the individual written disclosure of the accountable health plan's determination regarding any preexisting condition exclusion period that applies to that individual. The disclosure shall include all of the following information:

1. The period of creditable coverage allowed toward the waiting period for coverage of preexisting conditions.

2. The basis for the accountable health plan's determination and the source and substance of any information on which the accountable health plan has relied.

3. A statement of any right the individual may have to present additional evidence of creditable coverage and to appeal the accountable health plan's determination, including an explanation of any procedures for submission and appeal.

L. Periods of creditable coverage for an individual are established by presentation of the written certifications described in this section and section 20-1379. In addition to written certification of the period of creditable coverage as described in this section, individuals may establish creditable coverage through the presentation of documents or other means. In order to make a determination that is based on the relevant facts and circumstances of the amount of creditable coverage that an individual has, an accountable health plan shall take into account all information that the plan obtains or that is presented to the plan on behalf of the individual.

M. The department may enforce and monitor the issuance and delivery of the notices and certificates by accountable health plans and insurers as required by this section, the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations adopted to implement the health insurance portability and accountability act of 1996.

N. This section does not prohibit any health benefits plan from providing or offering to provide rewards or incentives under a wellness program that satisfies the requirements for an exception from the general prohibition against discrimination based on a health factor under the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 stat. 1936), including any federal regulations that are adopted pursuant to that act.

O. NOTWITHSTANDING ANY OTHER LAW, AN INSURER IS NOT REQUIRED TO PROVIDE A CERTIFICATE OF CREDITABLE COVERAGE IF THE FEDERAL LAWS THAT REQUIRE PROVIDING A CERTIFICATE OF CREDITABLE COVERAGE ARE SUPERSEDED BY THE PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS.